

Linda Meurer Interview

1. What is the best piece of leadership advice you've ever received?

"Make it about the product, not the person." A wise mentor of mine advised me to always remember to direct critique, debate, discussion of a product/program away from personalities, and toward the goal of making the product better. It is easy to become defensive when one's work is under a critical scrutiny – which we must remember whether we are the one doing or receiving the critique. This advice has guided me as a teacher and has also helped me to read critical feedback in a way that separates my personal feelings from the criticism of the work (though sometimes a cooling off period is needed).

2. What is one leadership experience, situation, or scenario that you've experienced that you wish everyone in family medicine (students, residents, physicians) could experience?

The most rewarding experiences for me are when my learners (students, fellows, partners) succeed, either through direct mentoring or with support of one of my programs. For example, when one of my former fellows goes up for promotion, or assumes a leadership position where they make an impact in the community or in the clinic; when a student or junior colleague receives a major award for accomplishments in community engagement, or funding to conduct their own research. Our learners' achievements extend our reach, and it is a source of great pride for me.

3. Why did you choose family medicine and what's your favorite aspect of it?

The longitudinal, relationship-centered, comprehensive nature of family medicine is my favorite aspect of our discipline. As I went through medical school, I considered nearly every specialty, but always came back to family medicine as the best fit, and knew I could incorporate aspects of other specialties (e.g. Pediatrics, Psychiatry, OB/Gyn) into my practice. I saw medicine de-personalized in other disciplines (e.g. referring to a young critically ill patient as "hepatitis girl"), and wanted to be the one who knew the patient by name and history – to be advocate, comforter and care coordinator.

4. What is the most memorable experience you have had when dealing with a patient?

One of my favorite memories is of a young woman who I began seeing at age 11, with her mother. At 17, she became pregnant (unplanned), and followed her and delivered her healthy baby girl. As with many young, single mothers, I worried about her future, her readiness to be a parent, and the future of her child. But as I walked into her room the following day, I found her sitting calmly in a chair by the window, sun shining through her long hair as she gazed lovingly at her nursing baby. She was the image of a young Madonna, perfectly at ease with her new role. Over the next few years, she married the young father, and they had two more children, whom I also delivered and cared for. Being a part of this 3-generation family was a privilege for me, and I felt a bond with them as I watched this family

grow, while growing into my own role of a family doctor.

5. What qualities make a great leader in family medicine? How have you taken these qualities into your practice and community outreach?

I think important leadership qualities include being an active listener, a reliable partner, and intentional about seeking and incorporating input from stakeholders and colleagues with a broad range of expertise. Especially for projects that will require effort and buy-in from others, it's important to see the problem and potential strategies from different perspectives. By seeing their ideas incorporated into a program or product, partners feel heard and valued, and may share greater investment in the success of the endeavor. Further, varied perspectives and expertise can help maximize relevance, quality and creativity of the work. When developing the Urban and Community Health Pathway at MCW, I worked with a diverse council of faculty from Family Medicine, Internal Medicine, Pediatrics, Psychiatry, Surgery, OB and Bioethics, and with community partners who understood local needs and assets. Early meetings involved laying out a framework for competencies and program goals, and led to a curriculum rich in addressing social determinants, implicit bias, and working in partnership with vulnerable communities to address health issues and help students develop empathy and cultural humility. It also engaged clinical and social science faculty and partners as potential advisors/mentors, teachers and facilitators for our didactic sessions – tapping a breadth of expertise that I couldn't possibly achieve alone.

6. Who or what inspired you to pursue family medicine?

When I started medical school, I didn't know much about the specialization of medicine. I envisioned becoming a 'doctor,' taking care of families over time – but especially caring for moms and children. I was disheartened when a classmate told me I couldn't do both, but would have to “choose a specialty.” Not long after, I went to a Family Practice Interest Group meeting, where a family physician told us about his career. I recall his relaxed, congenial and practical nature was a striking contrast to the professors I had met by then, and I was struck by the “normalcy” of the conversations. That meeting was my first “ahah!” moment, when I realized I COULD see whole families, build long-term relationships with my patients, and care for them regardless of their presenting condition.